

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34578**
Registrar's No. **66**

FILED NOV 12 1943

Registration District No. **4173**

Primary Registration District No. **4173**

1. PLACE OF DEATH:

(a) County **Douglas**
(b) City or town **AVA**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **/**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether)
In this community. (Specify whether)
years, months or days

3. (a) PRINT FULL NAME **Annie Ellison**

3. (b) If veteran, name war. 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, **Widowed**
6. (b) Name of husband or wife **Asa Ellison** 6. (c) Age of husband or wife if alive. years
7. Birth date of deceased **January 8 1869**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 7 20 hr. min.

9. Birthplace **Marshfield, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Homemaker**

11. Industry or business

12. Name **Jesse Andrews**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Martina Turner**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Doris Childress**
(b) Address **Diggins, Missouri**

17. (a) **Burial** (b) Date thereof **8-30-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ellison**

18. (a) Signature of funeral director **Clinkingbeard Funeral H**
(b) Address **Ava, Missouri**

19. (a) **10-1-43** (b) **Mr. J. R. Spaullock**
(Date received from registrar) (Registrar's signature)

1056 (Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Douglas**
(c) City or town **AVA** (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **28**
year **1943** hour **7** minute **4** A. M.

21. I hereby certify that I attended the deceased from **Aug 28** 19 **43** to **19 43**
that I last saw him alive on **Aug 28** 19 **43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Heart attack**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature **R. M. Norman** (M. D. or other)
Address **Ava Mo** Date signed **Aug 31/43**

Duration about **30 min**

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 6;

District File Number 1043-1182

Date Filed OCT 28 1953

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7706

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:
(a) County Douglas
(b) City or town Arifa
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Annie Ellison
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 2 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan. 8 1868 (Month) (Day) (Year)

8. AGE: Years 74 Months 7 Days 3 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 28 year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ after on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to Heart attack Chronic myo carditis
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature R M Norison (M. D. certificate)
Address Arifa MO Date signed 200 11/2/43

Duration 3 min
Physician Robert
Underline the cause to which death should be charged statistically.

34578